

PROTON PUMP INHIBITORS (PPI's): Nebraska Medicaid Prior Authorization Process

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(Revised Criteria: Effective 3-1-04)

Example Brand Names	Generic Name
Aciphex®	Rabeprazole
Nexium®	Esomeprazole
Prevacid®	Lansoprazole
Prilosec® (Rx only version)	Omeprazole (Rx only version)
Protonix®	Pantoprazole

NOTE:

- **PRILOSEC over the counter (OTC) - does NOT require prior authorization if prescribed at one daily, but must be prescribed to allow Medicaid coverage.** A new prescription may also be required for patients changing from one form of omeprazole to another (e.g. from a capsule to a tablet).
- All new PPI's marketed after the effective date of this bulletin shall also be subjected to the criteria in this document.
- All prescriptions for PPI's, except Prilosec OTC, must be authorized before payment.
- Examples of gastrointestinal agents that do NOT require prior authorization.
 - ♦Prilosec OTC (one daily)
 - ♦Famotidine
 - ♦Aluminum/magnesium hydroxide
 - ♦Sucralfate
 - ♦Ranitidine
 - ♦Calcium carbonate

HOW IS AUTHORIZATION REQUESTED?

PRESCRIBER ---

By Contacting ACS Directly: The prescriber may request authorization by phone directly from the ACS Clinical Call Center by calling or faxing the patient's diagnosis and the other required information.

1. Phone: 1-866-506-4379

2. FAX: 1-866-759-4115

(A fax request form is enclosed and is also available at www.hhs.state.ne.us/med/pharm/ .)

OR

By Providing the Pharmacist with the Needed Information: In certain situations, as noted on the next page, the prescriber may write the needed information on the prescription. The pharmacist will call or fax the information to ACS.

PHARMACIST ---

The dispensing pharmacist may use medical information provided by the prescriber to request authorization by phone directly from the ACS Clinical Call Center by calling or faxing the patient's diagnosis and the other required information. The pharmacy must maintain this written information for the same length of time as the prescription record is required to be maintained by statute or regulation. Electronic storage/imaging shall meet this requirement.

1. Phone: 1-866-506-4379

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WHAT INFORMATION IS NEEDED?

Note: Prilosec OTC does NOT require prior authorization if prescribed at one daily! Requests for coverage of any other PPI must (a) document why Prilosec OTC is therapeutically not appropriate for this patient, (b) provide the diagnosis, and/or (c) meet the "other requirements for Prescriber". Providing (a) and (b) may meet the criteria for authorization for the first 2 diagnoses below. Providing (a), (b) and (c) may meet the criteria for authorization for diagnoses 3-8 below. The prescriber may phone or fax this information directly to ACS using the attached form and attaching needed documentation.

Diagnosis	Duration of Authorization	Other Information
1. Pathological Hypersecretory Condition (Zollinger-Ellison Syndrome)	Lifetime	Diagnosis may be written on prescription.
2. Active GI Bleed; Active Gastric Ulcer; or Active Duodenal Ulcer	8 weeks	Diagnosis may be written on prescription. Approval is for 8 weeks therapy of once daily dosing. Requests to extend must be referred to the State. NOTE: <i>Histamine 2 Receptor Antagonists (H₂RA's) are covered for maintenance therapy without prior authorization.</i>

Diagnosis	Duration of Authorization	Other Requirements For Prescriber	Other Information For Prescriber
3. Barrett's Esophagus	Lifetime	Documentation of EGD within previous 2 years. Please include copy of report with request.	
4. History of recurrent (2 or more) upper GI bleed(s)	Lifetime	Documentation of history of GI bleed(s) including any dates of hospitalization or transfusions.	
5. Erosive Esophagitis (EE)	Lifetime	Documentation of grade II or greater EE diagnosed by endoscopy within previous 2 years. <i>Please include copy of report with request.</i>	
6. Helicobacter Pylori (HP)	BID for 14 days with 1 refill	PPI must be used in combination with other HP treatment modalities. Use of combination prescription will meet this requirement.	NOTE: <i>Histamine 2 Receptor Antagonists (H₂RA's) are covered for maintenance therapy without prior authorization.</i>
7. Gastroesophageal Reflux Disease (GERD)	6 months	Documentation of a recent failure (i.e., within the last 6 months) of 8 continuous weeks of therapy with an acute dose of a prescription strength H ₂ RA or Prilosec OTC.	NOTE: <i>Histamine 2 Receptor Antagonists (H₂RA's) are covered for maintenance therapy without prior authorization.</i>
8. Hyperacidity of Cystic Fibrosis (HCF)	1 year	Documentation of a recent failure (i.e., within the last 6 months) of 8 continuous weeks of therapy with an acute dose of a prescription strength H ₂ RA or Prilosec OTC.	NOTE: <i>Histamine 2 Receptor Antagonists (H₂RA's) are covered for maintenance therapy without prior authorization.</i>

Please note: The Department may request chart documentation to verify above information.

SPECIAL CONSIDERATION: For all other PPI uses that do not meet one of the above 8 prior approval criteria, a request with supportive documentation must be directed to: Pharmacy Consultant, Medicaid Division, P.O. Box 95026, Lincoln, NE 68509-5026; FAX (402) 471-9092.

Note: When an OTC or generic PPI becomes available, only the OTC or generic form of the drug will be authorized for initial new prescriptions; prior authorization will still be required through the above process for the generic form of the drug. Medicaid will consider a brand name PPI for new prescriptions **ONLY AFTER** documentation of failure of at least 8 weeks of therapy with the OTC or generic form of the drug.

MEDICAID RECIPIENT:

Name: _____
First Last
Medicaid #: _____
Date of Birth: _____

Name: _____ Request Date: _____
Phone #: (____)-_____

This request is being submitted for the following PPI drug: **NOTE: Prilosec OTC does NOT require prior authorization if prescribed at one daily.**

Drug Name:	Strength:	Administration Schedule:	Length of Therapy:
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Diagnosis for use of this medication is as follows (check box or boxes that apply). See documentation requirements on Page 2.

1. Pathological Hypersecretory Condition (Zollinger-Ellison Syndrome)	<input type="checkbox"/> Yes	If yes, and meets #10 below, approved for lifetime therapy.
2. Active GI Bleed, Active Gastric Ulcer or Active Duodenal Ulcer	<input type="checkbox"/> Yes	If yes, and meets #10 below, approved for 8 weeks therapy.
3. Barrett's Esophagus	<input type="checkbox"/> Yes	If yes, and meets #10 below, approved for lifetime therapy.
4. History of recurrent (2 or more) upper GI bleed(s)	<input type="checkbox"/> Yes	If yes, and meets #10 below, approved for lifetime therapy with documentation.
5. Erosive Esophagitis grade II or greater by endoscopy verification	<input type="checkbox"/> Yes	If yes, and meets #10 below, approved for lifetime therapy with copy of endoscopy report.
6. Helicobacter Pylori treated with combination therapy	<input type="checkbox"/> Yes	If yes, and meets #10 below, approved for 14 day b.i.d. therapy with one refill

7. Gastroesophageal Reflux Disease	<input type="checkbox"/> Yes If yes and meets #9 and #10 below, approved.*
8. Hyperacidity in Cystic Fibrosis	<input type="checkbox"/> Yes If yes and meets #9 and #10 below, approved.*

9 (a) For either diagnosis 7 or 8 above, has there been a recent failure of 8 weeks continuous therapy with an acute dose of a prescription strength H₂RA? ☐ Yes ☐ No

9 (b) If yes, name medication: _____
 Date of trial from: ____/____/____ to ____/____/____

10. Prilosec OTC/omeprazole is therapeutically inappropriate for this patient, because of: (a) allergy-describe reaction _____, or (b) therapeutic failure of at least 8 weeks continuous therapy within the last 6 months-dates last taken: from _____ to _____, or (c) other-please describe _____.

*Initial treatment and failure with an H₂RA must be followed by treatment with Prilosec OTC. Initial treatment and failure with Prilosec OTC does not require treatment with an H₂RA.

Please note: The Department may request chart documentation to verify above information.

REQUESTS FOR SPECIAL CONSIDERATION: For all other PPI uses that do not meet one of the diagnoses and criteria above, a request with supportive documentation must be directed to: Pharmacy Consultant, Medicaid Division, P.O. Box 95026, Lincoln, NE 68509-5026; Fax (402) 471-9092.

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